

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

XC 1987857 SL-29772

63-049809

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

13093

FILED JAN 9 1964

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
Length of stay in 1b 10 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET ADM HOSPITAL		d. STREET ADDRESS (If outside, give location) 3940 A. ASHLAND AVE.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last LENZIE NESBITT		Month Day Year DECEMBER 29 1963	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-26-1899
9. AGE (last birthday) 64		10. IF UNDER 1 YEAR Months 8 Days 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PULLMAN PORTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) BRINKLEY ARK.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JOHN NESBITT		13b. MOTHER'S MAIDEN NAME MAUDY JEFFERS	
14. NAME OF HUSBAND OR WIFE LEONA NESBITT		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I	
16. SOCIAL SECURITY NO.		17. INFORMANT LEONA NESBITT SEE 2 Above	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS AND PNEUMONIA DUE TO (b) INTRAPERITONCAL CARCINOMA DUE TO (c) CARCINOMA OF PANCREAS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS UNKNOWN UNKNOWN	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION VA		20g. COUNTY STATE	
21. attended the deceased from 12-4-63 to 12-29-63 and last saw him alive on 12-29-63 Death occurred at 6:50 PM on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) FRED M. WOOD Fred M. Wood M.D.	
22b. ADDRESS VAH, ST. LOUIS, MISSOURI		22c. DATE SIGNED 12-29-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-6-1964	
23c. NAME OF CEMETERY OR CREMATORY National		23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Missouri	
24. FUNERAL DIRECTOR Ellis Funeral Home, Inc. 2820 Stoddard St.		25. DATE RECD. BY LOCAL REG. JAN 2 1964	
26. REGISTRAR'S SIGNATURE Earl Smith M.D.			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON

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Rev. 4/59

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00-107-1072

1-1-1953

2281

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Fulton E. Culkin

Licensed Embalmer No. 4198

P. O. Address St Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.